NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF JEFFERSON CITY (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 (X3) DATE: COMPL (X4) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 STREET ADDRESS, CITY, STATE, ZIP CODE 336 WEST OLD ANDREW JOHNSON HWY JEFFERSON CITY, TN 37760 PROVIDER'S PLAN OF CORPORTION (EACH DEFICIENCY MUST BE APPECIANCES) (D) PROVIDER'S PLAN OF CORPORTION	8654755236 P 11/1 PRINTED: 01/09 > / / FORM APPRI	8655945759 >> 5+4 21221	86 45	Dept of Health AND HUMAN SERVICES & MEDICAID SERVICES	RS FOR MEDICARE	CENTE
AME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF JEFFERSON CITY PAGED AND SUMMARY STATEMENT OF DEFICIENCIES (EACH LEPRICE CY MUST BE PRECEDED BY FULL TAG NEGULATORY OR LISC IDENTIFYING INFORMATION) EQUILATORY OR LISC IDENTIFYING INFORMATION) FOR HOUR fire-rated construction (with ½ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 6.4.1 and/or 19.3.5.4 protects heazerdous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the fire rated construction. The findings include: Observation on January 7, 2014, at 1:30 p.m. revealed the unit 2 nurses station has 2 penetrations in the 1 hour fire rated ceiling assembly. This finding was verified by the administrator during the exit conference on January 7, 2014.	OMB NO. 0938	JETIPLE CONSTRUCTION DING 01 - MAIN BUILDING 01	(X2) MULTIP A. BUILDING	(X1) PROVIDER/SUPPLIER/CLIA		
SUMMARY STATEMENT OF DEFICIENCES TAG PROVIDERS PLANDE CORRECTION (EACH DEFICIENCY) FREGULATORY OR LSC IDENTIFYING INFORMATION) K 029 NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with % hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the fire rated construction. The findings include: Observation on January 7, 2014, at 1:30 p.m. revealed the unit 2 nurses station has 2 penetrations in the 1 hour fire rated ceiling assembly. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on January 7, 2014.	01/06/201					
FREEDRY TAG SEACH DEPROJECTORY MIST BE PERCECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) K 029 NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with % hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system in occordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 Inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the fire rated construction. The findings include: Observation on January 7, 2014, at 1:30 p.m. revealed the unit 2 nurses station has 2 penetrations in the 1 hour fire rated construction of the building. Any areas found will be repaired with approved materials. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Maintenance Director/designee will conduct a monthly audit for 3 months to	REW JOHNSON HWY	336 WEST OLD ANDREW J] :			
K 029 NFPA 101 LIFE SAFETY CODE STANDARD SS=D One hour fire rated construction (with % hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the fire rated construction. The findings include: Observation on January 7, 2014, at 1:30 p.m. revealed the unit 2 nurses station has 2 penetrations in the 1 hour fire rated ceiling assembly. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on January 7, 2014. The Maintenance Director/designee will conduct a monthly audit for 3 months to	S PLAN OF CORRECTION (X) ECTIVE ACTION SHOULD BE COMPLE ENCED TO THE APPROPRIATE DATE	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED	ID PREFIX	MUST RE ORGACION AV A	(EACH DEFICIENCY	PREFIX
intervaled doors) of an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 lnches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the fire rated construction. The findings include: Observation on January 7, 2014, at 1:30 p.m. revealed the unit 2 nurses station has 2 penetrations in the 1 hour fire rated ceiling above the Unit 2 nurses station with approved materials on or before 2/7/14. How will you identify other residents having the potential to be affected by the same deficient practice? Maintenance Department will examine the facility to ensure there are no additional penetrations in the fire rated construction of the building. Any areas found will be repaired with approved materials. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Maintenance Director/designee will conduct a monthly audit for 3 months to		K029 NFPA 101 LI	K 029			K 029 SS≃D
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The findings include: Observation on January 7, 2014, at 1:30 p.m. revealed the unit 2 nurses station has 2 penetrations in the 1 hour fire rated ceiling assembly. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on January 7, 2014. It is finding to ensure there are no additional penetrations in the fire rated construction of the building. Any areas found will be repaired with approved materials. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Maintenance Director/designee will conduct a monthly audit for 3 months to	nt practice?	the same deficient pr	ال أ	M the tocility follows:	Deservation	
revealed the unit 2 nurses station has 2 penetrations in the 1 hour fire rated ceiling assembly. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on January 7, 2014. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Maintenance Director/designee will conduct a monthly audit for 3 months to	there are no additional e fire rated construction	penetrations in the fire	P			ļ.
This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on January 7, 2014. What systemic changes will be made to ensure that the deficient practice does not recur? The Maintenance Director/designee will conduct a monthly audit for 3 months to	Any areas found will be roved materials.	of the building. Any a repaired with approved	r	ITSES station had a	penetrations in the 1 t	ŗ
conduct a monthly audit for 3 months to	langes will be made to	what systemic change ensure that the deficie	Jw e:	doed by the administrator	This finding was verification and acknowle	1 d
construction.	y audit for 3 months to	conduct a monthly audiensure our facility mair	er			
How will the corrective action be monitored to ensure the deficient	rective action be ure the deficient	How will the corrective monitored to ensure the	m	PUDPLUT DEPART	RECTOR'S OR BROWNERS	TORY DI
FORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE TITLE (X6) DX Siency Statement anding with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined the date of survey whether the patients. (See instructions.) Except for nursing homes, the findings stated determined	(X8) DATE		\rightarrow	NELLAND E.	John Hom	one

Any otho cuments are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rom participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4KWQ21

Facility ID: TN4503

If continuation shoot Page 1 of 3

other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 's following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

FORM CMS-2567(02-99) Provious Varsions Obsolete

2014-01-22 13:15

TN Dept of Health

Event ID: 4KWQ21

Facility ID: TN4503

DEPAR CENTE	TMENT OF HEALTH RS FOR MEDICARE	Dept of Health AND HUMAN SERVICES & MEDICAID SERVICES	86	555945759 >>		INTED: FORM	01/09/2014 APPROVED
LA IOL CINCIA	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIN	PLE CONSTRUCTION G 01 - MAIN BUILDING 01	ī	(X3) DAT	0938-0391 E SURVEY PLETED
1 1111		445275	B. WING)		
NAME OF	PROVIDER OR SUPPLIER			STREET ARREST	<u> </u>	01/	06/2014
LIFE CA	RE CENTER OF JEFF	••	1	STREET ADDRESS, CITY, STA 336 WEST OLD ANDREW J JEFFERSON CITY, TN 3	OHNSON HWY	· - •	
PREFIX TAG	THE CHARGE OF THE PRICE.	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CO IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED	OF CORRECTION	JE ATE	(X5) COMPLETION DATE
K 062	i		K 062	Maintenance Departs heater in the attic spa system above room #	ice for the sprin	nkier	व्याद्यक्ष
	failed to provide the heat.	not met as evidenced by: on and testing, the facility sprinkler riser with adequate		thermometer was ins riser room on 1/29/14 be monitored. If tem	talled in the sp	rinkler re can below	
	Sprinkler riser to permanent heat sour two (2) louvered oper the sprinkler riser materials. The heater in the system above room 2 tested. These findings were director and acknowless.	ing on January 7, 2014, at .m. revealed the following: om does not have any ce Installed. The room has		40 degrees Fahrenheit, radiant heat will be provided to this room to maintain the appropriate temperature. This was Stuart Hurwitz's recommendation. How will you identify other residents having the potential to be affected by the same deficient practice? Maintenance Department examined all heaters in the attic space to ensure they are working properly. Maintenance Department also placed thermometers in each attic fire compartment throughout the facility to ensure appropriate temperatures are maintained for areas susceptible to sprinkler system freezing. If temperature			
Rm CMS-2587(i	02-99) Previous Versions Obs	plete Event ID: 4KWQ21	v v v e n by	n any of these areas diegrees, additional heavill be provided. This n or before 1/31/14. What measures will by hat systemic change usure that the deficit of recur? laintenance associates of ED by 1/31/14 to change approximate that the deficit of the control o	at and/or insular was all complete put into places will be made and practice de were inservice eck and log	ce or e to	

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES		PRINTE	0: 01/09/2014
CENTE	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES			MAPPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	LTIPLE CONSTRUCTION (X3) DA	TE SURVEY MPLETED	
		445275	B. WING	·	10010044
in the OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	/06/2014
LIFE CA	RE CENTER OF JEFF	ERSON CITY		336 WEST OLD ANDREW JOHNSON HWY	
				JEFFERSON CITY, TN 37760	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	,	(X5) COMPLETION DATE
K 062	Continued From pa	ge 1	K	and to immediately add heat or insulate to 362 resolve any issues that arise.	2/22/14
	Based on observation failed to provide the heat. The findings include Observation and test 1:50 p.m. and 5:10 p.m	s not met as evidenced by: ion and testing, the facility sprinkler riser with adequate sting on January 7, 2014, at c.m. revealed the following: com does not have any irce installed. The room has enings in the exterior wall by aking it susceptible to e attic space for the sprinkler 204 was not working when e verified by the maintenance eledged by the administrator erence on January 7, 2014.		Maintenance Director/designee will perform a weekly audit of temperatures for all sprinkler areas to ensure temps are being logged and any issues addressed. This audit will continue for 12 weeks or until 100% compliance is achieved. Maintenance Director/designee will perform a monthly audit of attic heaters for 3 months to ensure they are all in proper working order. Any issues found will be immediately repaired. How will the corrective action be monitored to ensure the deficient practice will not re-occur, i.e., what quality assurance program will be put into place? The Maintenance Director/designee will report findings of the audits to the interdisciplinary PI committee for 3	
				months or until 100% compliance is achieved. The Performance Improvement committee includes the Executive Director, Director of Nursing, Medical Director, Consultant Pharmacist, Director of Rehabilitation Services, Director of Health Information, Director of Social Services, Director of Food Services, Director of Maintenance, Staff Development Coordinator, Skilled MDS Coordinator, Director of	

DESARTMENT OF HEAL	TH AND HUMAN SERVICES		PRINTS	D: 01/09/2014
CENTERS FOR MEDICAL	RE & MEDICAID SERVICES		FOR	M APPROVED
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION (X3) D	O. 0938-0391 ATE SURVEY OMPLETED
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is wif OF PROVIDER OR SUPPLIE	R	 -	STREET ADDRESS, CITY, STATE, ZIP CODE	1/06/2014
LIFE CARE CENTER OF JE			336 WEST OLD ANDREW JOHNSON HWY JEFFERSON CITY, TN 37760	
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI; TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Based on observ	page 1 is not met as evidenced by: ation and testing, the facility he sprinkler riser with adequate	ΚO	Environmental Services, and other 62 Interdisciplinary team members. The PI committee will review the results of these audits. If deemed necessary by the committee, the process will be evaluated/revised.	2 32 14
1:50 p.m. and 5:1 1. Sprinkler riser permanent heat s two (2) louvered of the sprinkler riser freezing. 2. The heater in system above roo tested. These findings we director and acknow during the exit constant of the system above footested. These findings we director and acknow during the exit constant of the system above roo tested. SS=D Smoking regulation less than the follow (1) Smoking is procompartment when combustible gases and in any other had area is posted with or with the internation.	esting on January 7, 2014, at 0 p.m. revealed the following: room does not have any curce installed. The room has penings in the exterior walf by making it susceptible to the attic space for the sprinkler m 204 was not working when re verified by the maintenance cowledged by the administrator ference on January 7, 2014. AFETY CODE STANDARD	K 0€	6 K066 NFPA LIFE SAFETY CODE STANDARD What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? On 1/28/14 two self-closing steel cans were ordered (one for each of the two smoking areas). Two metal buckets were also ordered to go down inside the cans in order to provide the required self-closing cover device into which ashtrays can be emptied. This was Stuart Hurwitz's recommendation.	3 33 14

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTE	RS FOR MEDICAF	RE & MEDICAID SERVICES		(MAPPROVED N 0038-0304
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		445275	B. WING	·	01	Incinos s
€ 0F	PROVIDER OR SUPPLIE	R	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	/06/2014
LIFE CA	RE CENTER OF JER	FFERSON CITY	j	336 WEST OLD ANDREW JOHNSON HWY JEFFERSON CITY, TN 37760		
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	design are provided permitted. (4) Metal contained devices into which	ers with self-closing cover a sahtrays can be emptied are of all areas where smoking is	К	How will you identify other residential to be affected the same deficient practice? No other residents have the potential affected because we are switching to approved container in both of our to smoking areas. What measures will be put into powhat systemic changes will be madensure that the deficient practice not recur?	d by al to be to an wo lace or ade to	2 33 14
	Based on observation devices into which The findings included to the findings included the findings included the findings included the finding was well as finding was	anuary 7, 2014 at 5:30 p.m. noking areas were not provided ters with self-closing cover a ashtrays can be emptied into,		Maintenance director/designee will weekly to ensure that the two new sclosing cover devices into which as can be emptied are in place and functioning properly. This audit wiperformed for 3 months or until 100 compliance is achieved. How will the corrective action be monitored to ensure the deficient practice will not re-occur, i.e., wh quality assurance program will be into place? The Performance Improvement conincludes the Executive Director, Director, Director, Director of Rehabilitati Services, Director of Health Inform Director of Social Services, Director Food Services, Director of Mainten Staff Development Coordinator, Sk MDS Coordinator, Director of	self- shtrays sili be 0% nat e put nmittee rector sultant ion ation, or of ance,	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		& MEDICAID SERVICES					APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DAT	E SURVEY IPLETED
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	RE CENTER OF JEFF			_	36 WEST OLD ANDREW JOHNSON HWY EFFERSON CITY, TN 37760		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC (DENTIFYING INFORMATION)	ID PREFIX TAG	x .	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 066	design are provided permitted. (4) Metal containers devices into which a	ge 2 combustible material and safe in all areas where smoking is with self-closing cover ashtrays can be emptied are all areas where smoking is	КО	66	Environmental Services, and other Interdisciplinary team members. The committee will review the results of audits. If deemed necessary by the committee, the process will be evaluated/revised.	ne PI f these	<u> त्रुविविधि</u>
:	Based on observati provide metal contain	not met as evidenced by: on, the facility failed to iners with self-closing cover ishtrays can be emptied into.		:			
	The findings include	:		·			
<u> </u> 	revealed 2 of 2 smo with metal container devices into which a that are readily avail						
į	director and acknow	ified by the maintenance ledged by the administrator rence on January 7, 2014.		:			
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